



True Friends
 10509 108th St. NW
 Annandale, MN 55302
registration@truefriends.org
 952.852.0101

FOR OFFICE USE ONLY:
 Date Rec'd. _____
 Session _____

PHYSICAL EXAMINATION

This Physical Examination form must be completed and signed by a Licensed Physician. We request this form or a copy of a physical dated no later than **12 months** from your camp date to ***be received at the time of applying for any True Friends program.***

Name: _____ Date of Birth ____/____/____ Male ____ Female ____
 Last First Middle Initial

Diagnosis: _____
 Is any condition present, which may result in an emergency? Please describe: _____

Allergies: _____

EXAMINATION COMPLETED BY DOCTOR

Height: _____	Weight: _____	Ideal Body Weight: _____
Pulse: _____	BP: _____	Temp: _____
Head/Scalp: _____	Lungs: _____	
Eyes: _____	Cardiac: _____	
Vision: _____	Upper Extremities: _____	
Ears/Hearing: _____	Lower Extremities/Edema/Circulation: _____	
Mouth/Throat/Nose: _____	Back/Spine: _____	
Neck/Thyroid & Lymph Sys: _____	Perineum: _____	
Nervous System/Pupil Reaction/Reflexes/Gait/Sensations: _____	Breast Exam: _____	Pap Smear Performed: _____
Abdomen: _____	Testes Exam: _____	Free from communicable disease: YES / NO
PREVIOUS ILLNESS (give age when these occurred): Chicken Pox _____ Measles _____		
Mumps _____ Scarlet Fever _____ Other _____		
IMMUNIZATION HISTORY: Please give dates (month/year) of immunizations and most recent booster dates:		
(DPT) _____ MMR _____		
Polio _____ Smallpox _____ TB test _____		
Influenza _____ Hepatitis b series _____, _____, _____ Tetanus Booster (required) _____		

Is client currently receiving: Physical Therapy _____ Speech Therapy _____ Psychological Therapy _____
 Other Therapy _____ (please describe): _____

ACTIVITY RESTRICTIONS:

List any conditions, operations or known serious injury that may affect activity level: _____
 Are there medical reasons to restrict this person from participating in an overnight camp out? (i.e. sleeping in a tent or on the ground?)
 No _____ Yes _____ if Yes, please explain _____
 Are there medical reasons to limit or restrict this individual from participating in the swimming program?
 No _____ Yes _____ if Yes, please explain _____
 Are there medical reasons to limit or restrict this individual from participating in the horseback riding program?
 No _____ Yes _____ if Yes, please explain _____
 Please list any other activity restrictions while individual is participating in a True Friends service. _____

Does applicant require daily skilled nursing care? No _____ Yes _____
 In the past year, has client's health status changed? No _____ Yes _____ If Yes, please describe _____

Is this client on medication? No _____ Yes _____
 Please list any routine medications **NOT** necessary during the service period: _____

Please provide a current copy of the individual's medication list with the completion of the physical examination form or add any special notes here: _____

Examining Physician's Name (please print) _____
 Signature _____ Date _____
 Address _____ Phone (____) _____
 City/State/Zip _____

In event of illness or injury occurring after this physical report, a descriptive note written by the caregiver or physician must be sent to True Friends prior to participant's arrival. Forms are available on our website at www.truefriends.org.